State of Rhode Island
Department of Administration / Division of Purchases
One Capitol Hill, Providence, Rhode Island 02908-5855
Tel: (401) 574-8100 Fax: (401) 574-8387

Solicitation Information
April 1, 2013

ADDENDUM # 2

LOI #7461250

LOI Title: # 7461250 Coordinating Care Entity for Connect Care Choice Community Partners Program Under the Medicaid Integrated Care Initiative

Bid Opening Date & Time: April 10, 2013 @ 10:30 AM (EST)

Notice to Vendors:

ATTACHED ARE VENDOR QUESTIONS WITH STATE RESPONSES.

NO FURTHER QUESTIONS WILL BE ANSWERED.

David J. Francis
Interdepartmental Project Manager

Interested parties should monitor this website, on a regular basis, for any additional information that may be posted.

Vendor Questions with State Responses-LOI # 7461250: Coordinating Care Entity for Connect Care Choice Community Partners Program

Question 1: Does each subcontractor, including all service providers and clinical providers, need to be named in the original submission? Every single doctor and other service provider?

Answer to question 1: If a subcontractor is going to be used in performing the CCE responsibilities, the subcontractor should be named in the original submission. It should be noted that the CCC*CP* members will continue to receive their Medicare and Medicaid covered benefits through existing Medicare and Medicaid Fee-For-Service providers. Reference Section 3.6 (Provider Networks) of LOI.

The CCE is responsible for coordination of services within these provider networks, not to develop the provider networks. CCE service responsibilities are described in Section 3. Program & Technical Requirements of the LOI on page 27.

Question 2: It seems like some of the recommendations from the stakeholder workgroups were not included. Why are there no requirements for remote patient monitoring of chronic conditions via telehealth, as recommended by the workgroup?

Answer to question 2: For the CCC*CP* program, Medicaid covered services will be provided by the Medicaid Fee-For-Service providers. Telehealth is still being evaluated in the Medicaid Fee-For-Service program. There are no requirements for remote patient monitoring of chronic conditions via telehealth.

Question 3: Will the deadline for responses be extended if bidders are not able to adequately respond to this complex LOI within the allotted time?

Answer to question 3: The deadline for responses is April 10, 2013 10:30am EST.

Question 4: What types of representatives and from what agencies will be on the Technical Review Committee?

Answer to question 4: State staff from EOHHS/Medicaid/Program Integrity and Division of Elderly Affairs will be on the Technical Review Committee.

Question 5: How do we determine if we need to complete the additional technical response for new bidders?

Answer to question 5: This procurement does not include an additional technical response.

Question 6: Is the initial telephonic health screening limited to telephone technology or can telehealth technologies like live video screenings with EMR integration be used instead? Would this type of complete clinical encounter preferred?

Answer to question 6: The Bidder is required to describe its plan to conduct the Initial Telephonic Health Screen. Bidders are encouraged to incorporate evidence-based best practices into their program design. See Section 3.8 of the LOI on page 41.

Question 7: Will specific required metrics be defined for the data reporting requirements?

Answer to question 7: Specific metrics will be defined for the data reporting requirements. Please refer to LOI Appendix C-3 Model Contract, Attachment H for preliminary reporting requirements.

Question 8: This section discusses how the consumer will have a choice with regard to which model they will enroll in: CCCCP, Health Plan, or PACE. Yet it then indicates the capacity to enroll new members is "particularly limited" with PACE, and "somewhat limited" with the CCCCP model. The Integrated Care Initiative estimates that 5,000 individuals will enroll in CCCCP. How will the state ensure consumer choice and access if more than 5,000 individuals choose the CCCCP model and / or opt out of the Health Plan model? Will there be caps on the number of individuals in the CCCCP model? (Section 2.6 Enrollment Approach)

Answer to question 8: The State does not envision a cap on the number of individuals in the CCC*CP* model. The model is driven by members who receive their primary care in a CCC practice. People who receive their primary care in a CCC*CP* practice. Capacity for the CCC*CP* model is driven by member capacity within the 17 CCC practice sites. The state is ensuring is ensuring choice through MCO or participating CCC practice enrollment. The 5,000 enrollment is based the current CCC practice site enrollment and an estimate of the likely enrollees from members who are MMEs. Appendix A of the LOI provides detail on the target populations for this program. For clients interested in the PACE program, information will be provided upon request.

Question 9: How much control does the CCE have over influencing the performance of community providers?

Answer to question 9: The CCC*CP* is designed to improve care coordination for members. The CCE should build a strong collaborative relationship with community providers to ensure members are being maintained in the community. The CCE responsibilities will include performance monitoring and feedback to EOHHS. The CCE's data

management, quality assurance and quality improvement work are designed to improve member care coordination. Through the establishment of a CHT, the CCE will collaborate with CCC practice sites/nursing staff, directly engage families and members to facilitate the meeting of member needs and the ability to access appropriate care and community resources. (See Section 3 of the LOI).

Question 10: Is the Atlantes system considered an E.H.R.? If not, will the CCE be required to have an E.H.R. in addition to the Atlantes system?

Answer to question 10: The Atlantes system is not considered an EHR. There is no E.H.R. use requirement in this procurement.

Question 11: When will members be counseled about their choices should their first choice not meet their needs? For example, if a member receiving services through CCCCP would be better served through a Health Plan, does the CCE have the discretion to advise the member of this?

Answer to question 11: No, the CCE does not have the discretion to advise the member. The Model Contract, Section 2.04.08, details that non-biased enrollment counseling is the responsibility of the state.

Question 12: Does the CCE have the authority to establish a network of providers?

Answer to question 12: The CCE does not have the authority to establish a network of providers. The participating Medicare and Medicaid Fee-for-service providers will be the provider network for CCC*CP* members. The CCE must establish a CHT to work with the existing RI Medicaid and Medicare Fee-for-Service providers and the care management teams.

Question 13: What is the timeline or process for review of a disenrollment request?

Answer to question 13: See Section 2.05.07 and 2.05.08 of the Model Contract on page 26.

Disenrollment of Members

The State shall disenroll Members for any of the following reasons:

- Loss of Medicaid eligibility
- Members opt for the MCO care model
- Death
- Relocation out-of-State
- Adjudicative actions
- Change of eligibility status
- Placement in Eleanor Slater Hospital, Tavares, or an out of state residential hospital.

- Eligibility determination error
- Just cause (as determined by the State on an individual basis)

Disenrollment Requests from CCE
The Contractor may not disenroll a Member. All requests must be referred to the State for a disenrollment determination. The State reserves the right to disenroll Member whom the Contractor is unable to contact with contractual timeframes or cannot produce evidence of services provided within contractual timeframes. The Contractor may not request disenrollment of a Member because of an adverse change in the Member's health status or because of the Member's utilization of medical services, diminished mental capacity or uncooperative or disruptive behavior resulting from the Member's special needs (except when the Member's continued enrollment in the CCCP seriously impairs the CCE's ability to furnish services to either the particular Member or other Members. The Contractor shall submit written disenrollment policies and procedures for State approval.

Question 14: Would an organization that has a state contract to administer an existing State program be prohibited from subcontracting with the CCE?

Answer to question 14: An organization that has a state contract would not be prohibited, on the basis of that contract to administer an existing State program, from subcontracting with the CCE as long as it meets the requirements of the procurements and ensures that there is choice for members. There must be an assurance that there is no conflict of interest.

Question 15: Are all of the policies and procedures cited under Community Health Team (p. 43 of LOI) needed by submission or by start date?

Answer to question 15: All bidder responses will be evaluated against the requirements outlined in the procurement.

Question 16: Is the Home and Community Care Emergency Back-up Plan only for members who have transitioned out of the NHTP or Rhode to Home, or for all members of CCCCP?

Answer to question 16: The Contractor will be responsible for members transitioning from an institutional setting to a home and community based setting. The Contractor must establish an Emergency Back-Up Plan that will provide support members transitioning to the CCC*CP* program. The Contractor must have policies, procedures and practices that are approved by EOHHS to provide the functions meet related to reporting of critical incidences and to the Emergency Back-Up Plan and capacity of

member needs. Please see the Section 2.12.04 of the Model Contract and Section 4.6.4 E, pages 74 and page 56 of the LOI.

Question 17: In Section 3.10, specifically pages 55-56, the LOI discusses responsibilities currently conducted by the Alliance that will be conducted by the bidder under CCCCP. Can you clarify – does the CCE take over these tasks (critical incidence reporting, Emergency Backup Plan, etc.) ONLY WHEN the member has completed the NHTP or Rhode to Home Transition process and enters the CCCCP? Does the State expect the CCE to take over any care management responsibilities while the member is within the care management transition phase of NHTP (90 days) or Rhode to Home (365 consecutive days)?

Answer to question 17: The Contractor will assume the responsibilities of the Alliance for Better Long Term Care for members who ,at the end of the 365 days of *Rhode to Home* enrollment, have transitioned from the *Rhode to Home* demonstration to the CCCC*P* program. For members transitioned under the NHTP program, the CCE would provide the Emergency Back-up plan and critical incident report once the member transitions to a community based residence and lives in the residence. While the primary care management responsibility is with Nursing Home Transition Program and Rhode to Home Program, the CCE is responsible for member monitoring, CHT activities and reporting of issues to the State. See page 54 of the LOI.

Question 18: Regarding Enrollment Approach (p.25), will every Medicaid recipient in the State receive a letter? Will every MME receive a letter?

Answer to question 18: Every full MME will receive a letter, except populations that are excluded as identified in the Section 3.4 of the LOI.

Question 19: On page 26, LOI states "Members cannot however opt out to FFE Medicaid." Does this mean every Medicaid recipient must be in a Health Plan or CCCCP? Is there an additional option other than a Health Plan or CCCCP?

Answer to Question 19: For the populations defined in Section 3.09, every member must be enrolled in a managed care delivery system: CCC*CP* model, Health Plan model or PACE (see Section 2.5 of the LOI). There are some services excluded from Phase I of this integrated care initiative for population defined in Section 2.5 of the LOI.

Question 20: Regarding Risk Profiling (p. 38), who determines Level of Risk? CCE or State?

Answer to Question 20: The State has a process for determining the Level of Care for Home and Community Based Services, as outlined in the 1115 Demonstration Waiver. The CCE is responsible for assigning the risk level, Levels I or II as defined in Section XXX of the LOI. The CCE will be responsible for risk profiling and care determination based on the results of a health risk assessment. See Section 2.12.01 of the Model Contract on page 37-38.

Question 21: P. 38 refers to Risk Level I and Level II. Is this the same leveling that is done by the State, or are these levels distinct from Level of Care assessments?

Answer to question 21: The Risk Levels are distinct from the State's Level of Care assessments. The State has a process for determining the Level of Care for the Home and Community Based Services, as outlined in the 1115 Demonstration Waiver. The CCE is responsible for assigning the risk level, Levels I or II. The CCE would be responsible for risk profiling and care determination based on the results of a health risk assessment. See Section 2.12.01 of the Model Contract on page 37-38.

Question 22: LOI has members identified as "members who require, who are at risk of requiring, and who may benefit from…care management services." Are these 3 distinct categories?

Answer to question 22: Yes. Section 3.9 of the LOI details the care management being sought for the varying populations in the CCC*CP*.

Question 23: Are "Comprehensive Needs Assessment" and "Health Risk Assessment" used interchangeably?

Answer to question 23: Yes, they are the same.

Question 24: On p. 41, LOI states that "EOHHS reserves the right to designate the screening tool" for the Initial Telephonic Screen. Given this, is the bidder required to submit their own proposed Screening tool?

Answer to question 24: Yes. The LOI requires Bidders to describe the policies and procedures and practices that will be used in the screen, the instrument and protocols that will be used to document the screen and the information and formats that will be used to document the screen. Section 3.9 of the LOI addresses the necessary functionality of the screening tool.

Question 25: What is DEA's involvement in care management of this population?

Answer to question 25: DEA is a provider of care management services for Rhode Island elders. The CCE will work with DEA for community-based care coordination. The Contractor agrees to coordinate for the full range of covered services with Connect Care Choice, Office of Community

Programs, Department of Elder Affairs, and Community Health Team for those members eligible for the CCC*CP*. Reference the Model Contract, Sections 2.03.03 and 2.06.03.03 Coordination with Care Managers and pages 19 and 28, respectively.

Question 26: Does the CCE need to create the Health Risk Assessment? If so, will this be the assessment that is also used by CCC or OCP staff who do Health Risk Assessments? Does the state envision that all parties conducting in-home Health Risk Assessments (CCE, CCC, OCP) use the same assessment tool?

Answer to question 26: A State uniform assessment tool is envisioned. The Health Risk Assessment (HRA) created by the CCE will be the document used by all CCC*CP* parties involved with the care management of the member. An in-person HRA must include at a minimum the following assessment tools: PHQ9, SF-36 and the Katz functional assessment. The assessment tool must be approved by the EOHHS. See Section 3.9, page 41 of the LOI.

Question 27: P. 45: "The Bidders must employ only State licensed clinical staff for persons enrolled in the CCCCP program." Please clarify what type and level of licensure (if nurse, RN? LPN? If Social Worker, MSW? LICSW?) and for what role on the CCCCP – conducting assessments?

Answer to question 27: The State is seeking proposals from the Bidders for the qualifications the staff, with the appropriate state licensure, for the CCE positions as they relate to the requirements outlined in the LOI. A licensed, role-based Registered Nurse will be part of the CHT.

Question 28: p.47: "All Plans of Care are submitted to the State for authorization. Once authorized, the Bidder notifies the designated Lead Care Manager and distributes the Plan of Care to the multi-disciplinary Care Team members." What is the turnaround time for the State to authorize the Plan of Care?

Answer to question 28: All Plans of Care that include a request for LTSS services must be submitted to the State for authorization. The State anticipates the turnaround time for the LTSS Plan of Care in most cases to be within 48 hours during normal business hours should the request be within the established range outlined in the service calculator, or within 3 business days. Emergent cases may be expedited. Please reference the service calculator hours and description found in the Procurement Library at: http://www.eohhs.ri.gov/integratedcare/supportdocs/

Question 29: p.47 Bidder is required to demonstrate IT capacity, but must use Atlantes once operational. Do we need a system in place until Atlantes? What is timeline on Atlantes? Will Atlantes be in place of or in addition to a tool the bidder chooses?

Answer to question 29: The Contractor will be required to provide the IT capacity to support the care management activities and will be required to utilize the State's care management tool Atlantes, once the system is operational. Reference Model Contract, Section 2.12.03.04.02 Plan of Care on pages 45 and 48. The CEE will be required to use Atlantes. Atlantes is anticipated to be available Sept. 1, 2013. The State and the CCE will work together to ensure robust care management and IT capacity, in addition to Atlantes as needed.

Question 30: p.53-57 these pages seem to refer to members transitioned from either NHTP or RTH to CCCCP: Options counseling, transitioning process, ongoing care management, quality of life survey, additional services, critical incidences, Emergency backup plan, and affordable housing. Do these pertain to all CCCCP members, or just those transitioned out of NTP/RTH?

Answer to question 30: The Home and Community Care Emergency Back-up Plan are critical incidences requirements are required for members who have transitioned out of the NHTP or *Rhode to Home*. The CCE will be responsible for CHT services in collaboration with the NHTP and RTH Transition Teams established by the State.

The Procurement Library contains the NHTP description and the CMS approved *Rhode to Home* MFP Operational Protocol that the CCE must be familiar with.

See Section 2.12.04 of the Model Contract on page 37-38 and Section 3.10 of the LOI.

Question 31: p.58 "Program director is licensed to practice in the State of RI and trained in his or her field of specialty." What license or field is necessary?

Answer to question 31: The State does not specify one specific license required for this role. The individual must be able to carry out the stated duties for the role detailed in the Model Contract, Section 2.12.05.01 on page 56.

Question 32: Are Home and Community Based Waivers a part of CCCCP?

Answer to question 32: The HCBS are part of the CCC*CP.* See Section 2.12.03.04.02 of the Model Contract on page 46 and Section 2.5 of the LOI on page 19.

Question 33: Are Protective Services a part of CCCCP?

Answer to question 33: Yes. Referral to and coordination with Protective Services are a component of the CCC*CP* care management.

Question 34: Who generates the list of enrollees that is sent to the CCE?

Answer to question 34: EOHHS will generate the enrollment list on a monthly basis. See Section 3.4 of the LOI on page 32.

Question 35: P. 41: Comprehensive Needs Assessment for Level II may be conducted by State Staff from OCP, DEA, or CCE. Who would DEA send? Is this person connected to Protective Services?

Answer to question 35: The DEA Home and Community Care program services adults > 65. These adults may be receiving the care management services from the DEA Home and Community Care program. We're looking for CHT to coordinate services as needed with DEA and its network of providers; reference LOI Section 3.9 on page 39.

Question 36: Will DEA continue to have Case management responsibilities? For whom?

Answer to question 36: Yes. The CCE will work in conjunction with DEA for those members participating in DEA-sponsored programs. The DEA Home and Community Care program services adults > 65. These adults may be receiving the care management services from the DEA Home and Community Care program. Reference LOI Section 3.9 on page 43.

Question 37: What percentage of the approximately 5,000 enrolled in CCCCP will be risk level I?

Answer to question 37: It is envisioned that approximately half of the projected Members may be risk profiled at Level I. Please see LOI, Appendix C-3, Attachment F, Projected Enrollment, page 19.

Question 38: Is the prescribed Plan of Care currently in use (p.45)?

Answer to question 38: Elements of the prescribed Plan of Care are currently in use. The components of the Plan of Care being sought through the CCE are described in Section 3.9 of the LOI.

Question 39: Are custodial residents of Long Term Care eligible for participation in CCCCP?

Answer to question 39: Yes. Please see LOI Appendix C-3, Attachment F, CCC*CP* Projected Enrollment.

Question 40: On p. 26 of LOI, it states, "A consolidated Member Services call center team will be created to answer incoming calls and to implement or make changes and Health Plan and CCCCP assignments and to provide information about the PACE option." Will this be both managed and staffed by the State?

Answer to question 40: A combination of state management and contracted staff will support the Member Services call center. Information about the PACE program will be provided. See Section 2.6 of the LOI.

Question 41: On p. 25, LOI states, "For members not enrolled in a Health Plan or assigned to a specific CCC site, they will be sent a letter indicating that they have been auto-assigned to one of the Health Plans." Do all unaffiliated members get assigned into a Health Plan, and not the CCCCP? To ask another way, is "auto-assignment being equal and random" between the 2 Health Plans, or among 2 Health Plans and 1 CCCCP? If only the 2 Health Plans, then is CCCCP listed as an alternate choice in that same letter? Is any information provided about the PACE option in this letter?

Answer to question 41: All non-affiliated members will be auto-assigned to one of the Health Plans on an equitable basis. Once assigned, the newly-enrolled member will be given the opportunity to change their auto-assigned Health Plan or to enroll in the CCC*CP* or PACE if they choose to, within a six-week period during enrollment start-up. See Section 2.6 of the LOI on page 25.

Question 42: Please provide an example of monthly payment to the CCE using the capitation rates and estimates of population in each category. (This is so we can ensure we are applying the formula correctly.)

Answer to question 42: Please refer to the example provided in the LOI Appendix C-3, Attachment F. The premium multiplied by the projected enrollment would result in the monthly payment for the premium rating group.

Question 43: Please describe the involvement the CCE will have in managing the care of members living in a nursing facility on a custodial (long term) basis.

Answer to question 43: For members living in a Nursing Facility, the CCE will be responsible for conducting the transition coordination and analytic activities outlined in the LOI. Should a member in a Nursing Facility be identified as a transition candidate, the CCE would refer the member to the State NHTP or MFP program.

See Section 2.12.04 of the Model Contract on pages 37-38 and Section 3.10 of the LOI.

Question 44: How will the State provide the list of enrollees to the CCE? How much and what type of data on members conditions and utilization will accompany the list?

Answer to question 44: EOHHS will send an electronic enrollment file on a monthly basis. The State will also send data on the member utilization, level of care information, and assessment information including LTSS eligibility. See Section 3.4 of the LOI on page 32.

Question 45: What is the definition of LTSS for purposes of the Telephonic Health Screen to be conducted on "all new members not currently receiving long-term care services and supports (LTSS)…." ? (p. 41 LOI).

Answer to question 45: Long Term Services and Supports (LTSS) refer to a broad range of supportive services needed by members who have limitations in their capacity for self-care because of a physical, cognitive, or mental disability or condition and have met the LTC clinical and financial eligibility requirements. Please see Section Appendix C-3 Attachment F –CCC*CP* projected enrollment, Members residing in the community with no LTSS.

Question 46: Does the State plan on adding Nurse Care Managers to accommodate the increase in members?

Answer to question 46: EOHHS/OCP is evaluating staffing levels needed to serve the CCC*CP* membership. The establishment of the CCE & CHT is designed to meet the increased care coordination needs.

Question 47: (p. 47 LOI) Who in the State is authorizing the Plan of Care? What is the turnaround time for the State to authorize a plan once received?

Answer to question 47: All Plans of Care that include a request for LTSS services must be submitted to the State for authorization. The State anticipates the turnaround time for the LTSS Plan of Care in most cases to be within 48 hours during normal business hours should the request be within the established range outlined in the service calculator, or within 3 business days. Emergent cases may be expedited. Please reference the service calculator hours and description found in the Procurement Library at:
http://www.eohhs.ri.gov/integratedcare/supportdocs/

Question 48: Do you anticipate there being a "No-risk" group in addition to the Level I, Level II and "At-risk" populations in the CCCCP? Is every member receiving care management services, or are some just monitored for change in status?

Answer to question 48: All CCC*CP* members may receive some level of care management services at some point in time and they may be monitored for change and status. Please see Section 3.9 Care Management of the LOI.

Question 49: Will bidder have access to a data system flagging payment against Medicaid or Medicare as a way to identify medical events (MMIS?)?

Answer to question 49: The State will provide access to data and access to additional care management under the Atlantes system.

Question 50: What is the liability to CCE should the state delay the disenrollment of a member and the CCE believes there is considerable risk? Does CCE hold any liability for members that refuse assessment or services?

Answer to question 50: This is not a risk based contract. CCE does not hold any liability for Members that refuse an assessment or services. The CCE is responsible for documenting and reporting difficulties in outreaching to Members to the State. The State expects the CCE to continue to outreach to these members.

Question 51: What is the timeline or process for review of a disenrollment request?

Answer to question 51: Connect Care Choice *Community Partners* Member disenrollments will occur monthly, and the Contractor will normally be notified at the first financial cycle (schedule determined by EOHHS), for disenrollments effective at midnight the last day of the month in which the enrollment report was sent. Such disenrollments may be made effective sooner by mutual agreement of the State and Contractor. Contractor agrees to have written policies and procedures for complying with State disenrollment orders. The effective date of an approved disenrollment shall be furnished by EOHHS. See Section 3.4 of the LOI (page 32) and Section 2.05 of the Model Contract (p.23).

Question 52: Please define "non-MME" – we understand that these are members not eligible for Medicare, but please define categories further.

Answer to question 52: Non-MMEs are members who are not dual eligible for both Medicaid and Medicare; they are Medicaid-only members. Medicaid is the primary payer of covered medical services, included LTSS according to the Long Term Care eligibility requirements. Please see the Model Contract Definitions, page 14.

Question 53: Please define what you mean by Long Term Services and Supports (LTSS).

Answer to question 53: Long Term Services and Supports (LTSS) refer to a broad range of supportive services needed by members who have limitations in their capacity for self-care because of a physical, cognitive, or mental disability or condition and have met the LTC clinical and financial eligibility requirements. Please see Section Appendix C-3 Attachment F – CCC*CP* Projected Enrollment - Members residing in the community with no LTSS.

Question 54: If awarded the contract for the above-referenced program, how many client referrals and what types of home health care services should the provider expect on a weekly or monthly basis?

Answer to question 54: The home care services will be delivered by the current participating Medicare and/or Medicaid providers. We are not expecting the CCE to provide home health care services. The anticipated enrollment in the CCC*CP* program is approximately 5,000 members. Please see the LOI Appendix C-2, Attachment A - Integrated Care Initiative Data Book for information on service utilization for home care services by the targeted population for the Integrated Care Initiative (ICI).

Question 55: Will there be an opportunity prior to the April 2, 2103 submission deadline to appear before the Executive Office of Health Administration and/or the RI Department of Administration/Office of Purchases to present a home health agency model which incorporates a continuum of care which could prove beneficial to achieving the goals of the this program?

Answer to question 55: The updated submission deadline is 4/10/13 @ 10:30 AM. EOHHS does not plan to host any pre-submission presentations at this time.

Question 56: Will the Executive Office of Health and Human Services (EOHHS) please share the methodology used to construct the capitation rates in Attachment F. It would be helpful to bidders to understand the cost components, assumption, and trends used to build the rate in facilitate an ensure consistency of expectations regarding the agency's expectations. We are concerned about ensuring, especially for populations that are living in the community and using LTSS, that the rates are sufficient to ensure timely and appropriate access to services

Answer to question 56:
The ICI rate development for both the Health Plan model and the CCC*CP* model was based on experience for SFY 2011 projected forward for the period covered under the procurement. The cost component assumptions and trends are described in the procurement for the LOI # 7461245, Medicaid Integrated Care Initiative for the Rhody Health Options Program.
https://www.purchasing.ri.gov/RIVIP/StateAgencyBids/7461245.pdf

The rates were based on a systematic analysis as outlined in the Health Plan LOI, Appendix C, Attachment I Rate Setting Process document (Table 7). Projected PMPM costs are shown by capitation group for as follows:

LTC:	$4,877.50
MRDD:	$ 101.78
Waiver:	$1,869.10
SPMI:	$ 141.02
Community:	$ 106.59

Capitated rates for the procurement were set at 2% of the PMPM based on the anticipated savings from care management and improved transitions. The capitation rate for the Medicaid-only population is also set at 2% of the projected 2014 values. These differ from those shown in

the RHO LOI because the Medicaid-only population covered under the CCC*CP* LOI differ from those in the RHO LOI.

Question 57: What are the State's expectations regarding the circumstances under which additional members ("other key medical specialists or human service providers") would be included in the multi-disciplinary care team? In our experience, an expert with experience in the LTSS options available to consumers has been an important member of interdisciplinary care teams.

Answer to question 57: Bidders are encouraged to submit a comprehensive response that details a care team that meets the CCE's services requirements.

Question 58: There seems to be a word or phrase missing from the 5th bullet point on page 71 of the LOI regarding Assurances. Will you please clarify?

Answer to question 58: The bullet should read:

- **A statement** that the Bidder accepts an award made pursuant to this procurement between the State and the Bidder Organization.